Ministry of the Solicitor General

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October 17, 2022

Chantal Belisle
Registrar and Chief Executive Officer
Ontario College of Teachers

Re: **Recommendations from the Expert Review Concerning the Death of a Child – [OCC File No. 2020-2267]**

Dear Chantal Belisle,

The Office of the Chief Coroner (OCC) investigates deaths to determine the circumstances of death and, when indicated, provides recommendations to inform efforts to reduce further deaths. The Child and Youth Death Review and Analysis (CYDRA) unit at the OCC directly supports the development of effective recommendations for the prevention of further deaths of young persons in Ontario.

The goal of child and youth death review is to provide service-level, systemic, and structural recommendations aimed to prevent deaths, and to contribute to public safety and health by supporting recommendations that enhance the overall well-being of children, youth, their families, and communities.

Where CYDRA identifies a death of concern, there are different forms of death investigation (e.g. Local Death Review Table, Pediatric Death Review Committee for Children and Youth). At times, a decision may be made to request a review by a person with expertise relevant to the specific issues identified during a death investigation.

Dr. Kim Snow, an expert in children's services completed the attached review which outlines the findings and recommendations in relation to the unfortunate death of a young child. Recommendations specific to your organization and expectations regarding a response are outlined below.

For the item(s) relating to the Ontario College of Teachers, please see recommendation(s):

- 12 and 13

We request that you respond to the respective recommendation(s) within six months, i.e., by **April 17, 2023**, and that you provide the approach that will be taken to address each of the

recommendations directed to your organization. Please be advised that your response will be considered a public document and may be released to interested parties upon request.

Although the recommendations made in this expert review report are not legally binding, we trust that they will be given due consideration for implementation and that your organization will provide an explanation otherwise.

Please direct your response(s) to:

Dr. Julie Erbland, Manager, Child and Youth Death Review Analysis
Julie.Erbland@ontario.ca

Thank you in advance for your support in this important process. Please contact us should you have any questions.

Sincerely,

Dirk Huyer M.D.
Chief Coroner for Ontario

Expert Review Concerning the Death of a Child (2020-2267)

Prepared for the Office of the Chief Coroner

Dr. Kim Snow

September 2022

This document was produced by an expert Reviewer as a part of the work of the Child and Youth Death Review and Analysis (CYDRA) unit—pursuant to section 15(4) of the *Coroners Act*, R.S.O. 1990, c. 37, on the basis that it is to be used for the sole purpose of a coroner's investigation, and not for any litigation or other proceedings unrelated to the coroner's investigation. Moreover, the opinions expressed herein by the CYDRA may not necessarily take into account all of the facts and circumstances surrounding the death; therefore, the opinions expressed in this report are limited to the information provided and considered for the purposes of this review.

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Executive Summary

This review is aimed at assisting the Office of the Chief Coroner, Ontario, in the investigation into the death of a young child and identifying opportunities for meaningful recommendations that may inform the prevention of further deaths.

Children's Aid Societies (CAS) are one of few government-funded services with a legislative mandate exclusive to young people as enshrined under the Child, Youth and Family Services Act 2017 (CYFSA). As per Section 1, "The paramount purpose of this Act is to promote the best interests, protection and well-being of children" (CYFSA, 2017). As such, services should focus on the needs of the child. Notably absent in this case is the voice and perspective of the child. The child's concerns do not seem to drive service, nor do they seem to be engaged in safety planning, and this is surprising given that the mandate of the service is to protect the child.

Educators had expressed concerns about the conflict that they were witnessing with respect to this young child. There were two reports consistent with Section 125 of the Act (Police Officer; Early Childhood Educator), which provides for the enhanced duty to report for those in professional roles. Conflict was also evident during encounters with physicians, and a school principal who expressed concern for the well-being of children in the school, but no further reports of concern were made to a CAS.

Here we have examples of a child under 5, with known exposure to Intimate Partner Violence (IPV)[1], repeated examples of her father lying to the court and not complying with the orders of the court in the midst of an ongoing post-separation conflict lasting many years, and yet, the risk profile outlined within the child protection file does not appear to bring forward the cumulative risk, nor the prolonged and multiform exposure that the child was experiencing (exposure to family conflict, coercion, unexpected separations, and post-separation family conflict). Despite the child requiring treatment for distress and self-regulation during and post access/ parenting time visits, there is no direct intervention to reduce the potential risk the child was facing.

[1] Intimate Partner Violence is used synonymously within the report to encompass domestic violence and family violence.

The need to be more vigilant with a child under 5 is necessary due to the child's developmental vulnerability and because of the absence of eyes-on-the-child which reduces the risks from isolation (McCain, Mustard & McCuaig, 2011; Ministry of Justice British Columbia, 2013). This was not a situation of a child unseen by potential advocates, this was a child seen by numerous advocates, yet unheard, with few raising concern about the lengthy and multiform conflict that this young child was exposed to. The child protection workers may not have been able to prevent the death, but they did have evidence of emotional harm, and little was done by way of supporting the child directly with the challenging situations that she was facing during access visits/parenting time.[2] The ability to defer service to the community seems to have resulted in the child protection workers being challenged to continuously appraise the risks to this young person and see her distress.

Recommendations

Among other recommendations, this review calls for continuous appraisal of risk and safety planning directly with children, especially in cases with evidence of coercive control. The child protection workers would benefit from training modules focusing on IPV and coercive control in the context of post-separation parenting. In addition, Child Protection Information System (CPIN) should include case summary views to assist child protection workers in assessing the risk situation. Finally, case recording should articulate compliance to the Ontario Child Protection Standards (2016) within the case notes.

In total, 16 recommendations, including those above, have been developed with the hope that they will make a difference in preventing further deaths. The recommendations are aimed at the following: the lead Children's Aid Society, the Ministry of Children, Community and Social Services, the Ministry of the Attorney General, the Ministry of Education, the College of Psychologists of Ontario, the Ontario College of Social Workers and Social Service Workers, the College of Registered

[2] At the time of the child's death, the terms custody and access were used. As of March 1, 2021 amendments to the Divorce Act replaced the term access with parenting time. Therefore, throughout the report access visits/parenting time are used for clarity.

Psychotherapists, the Ontario College of Teachers, the College of Physicians and Surgeons of Ontario, and the Ontario Association of Children's Aid Societies. The full list of recommendations can be found on page 35.

The Child

The child discussed within this review lived only seventeen hundred and seventeen days. Over the course of those few days, she touched the hearts of many. She was the only child of a union that was characterized by conflict and that ended when she was nine months of age. Indications of Intimate Partner Violence (IPV) were reported during her mother's pregnancy, and, as her records would suggest, was a feature of her entire life.

By all accounts, she was loved by her parents, and her stepparent, and she was seen as a sensitive and precocious child by her caregivers. Often presenting with vague and poorly explained symptoms, she had repeated encounters with numerous medical practitioners, she was in play therapy, and her situation was a matter of concern for child welfare professionals. In addition to being a daughter, a big sister, and a cherished extended family member, she was also a valuable member of her school and community groups, and she had, at a very young age, aspirations of changing the world.

Terms of Reference

The purpose of this review is to assist the Office of the Chief Coroner in the investigation into the death of this young child and to identify opportunities for meaningful recommendations that may inform the prevention of further deaths.

Several objectives guided the work, including a mandate to:

- Provide expert advice related to issues, systems, systemic issues, and other factors that might have contributed to the death of the child;
- Develop a comprehensive understanding of the child's life trajectory, developmental factors, circumstances, and intersections with government and broader public service sector systems; and
- Identify risk factors, local or systemic issues, or gaps and offer suggested recommendations for intervention and prevention strategies that can inform the

prevention of further deaths.

The expert review gave specific attention to issues within the child welfare system and how those issues intersected with other systems and factors that may have contributed to circumstances leading to the death. Under the authority of the Coroner Act, R.S.O (1990) the Expert Reviewer was provided full access to all available seized and requested records, access to the Child and Youth Death Review and Analysis unit within the Office of the Chief Coroner as well as opportunity to meet with the child's family and the ability to access any literature, policies, and other material that was deemed appropriate by the reviewer.

Summary of Interactions with the Child Facing Services

All children in Ontario have access to services some of which are available to all children and others are more specialized services. Throughout this child's life, she was a recipient of the following services.

Medical Care

The child presented for over 100 OHIP billed visits, with care provided by more than 20 different physicians, and there were no emergency room visits. Over the course of her life, on average, she attended medical care twice per month. Her pediatrician was the attending in approximately a quarter of the physician visits. In the year prior to her death, she had dozens of physician encounters, including a visit a month preceding the death. On four occasions, she attended medical appointments for "family disruption, divorce", and once for "behavioural disorders of child and adolescence", and often for ill-defined conditions such as GI upset (not listed as viral), rashes (not listed as allergy), and a number of appointments for "other ill-defined conditions or not yet diagnosed conditions".

Post-separation conflict over medical care became a feature of her life, with conflict over the administration of medication or the need for prescribed treatment and at least one

instance of the father absconding with the child occurring in the context of a medical appointment.

School and Community Groups

The principal of the private school demonstrated sufficient concern about the conduct of the father that the principal had note-takers during calls with the father, and also expressed concerns about his presence at the school. However, the principal did not seem to have reported these concerns to a CAS. The young child also attended daycare and on one occasion the daycare management contacted the CAS due to concerns about the nature of the communications they were receiving regarding access visits/parenting time.

After many failed attempts to find psychosocial support for this very young child, a situation that the mother attributes to fear of reprisals from the father, and/or professional reluctance to get involved in the custody dispute, a psychologist was engaged to provide psychological support. While the psychologist did not independently report her concerns about the well-being of this child, she did raise concerns with the child protection worker, and wrote a letter outlining the impacts on the child from the ongoing conflict over access/parenting time.

Tertiary Response Services

The police had several encounters with this family and with this young child. On at least one occasion, the police reported concerns to a CAS. Three CASs were also involved.

Ontario's Child Protection System

The Child, Youth and Family Services Act

There is a legislated framework that sets out the protective entitlement for the children of Ontario, and this is comprised of legislative definitions, regulations, and child protection standards that a child welfare worker can apply to any case situation. The minimum standards are very basic and represent the minimum case intervention that should be undertaken at anytime a CAS believes a child may be at risk of maltreatment as defined under the Child, Youth and Family Services Act (CYFSA).

The Mandate to Protect Children

The protection of children in any society depends on the community to define, identify and report child maltreatment. In Ontario, the legislated safeguards for children experiencing child abuse and neglect are provided for in the CYFSA. This Act defines child maltreatment and identifies the forms of child abuse and neglect, the pre and proscriptive parenting standards, and the duty of professionals and community members to report suspicions that a child might be in need of protection.

The paramount purpose of the CYFSA "is to promote the best interests, protection, and well-being of children" (CYFSA, 2017). Other purposes outlined in the Act are to be considered secondary because they are conditional on being consistent with the best interests, protection, and well-being of the child. See Appendix A for the relevant sections of the Act.

The Functions of a CAS

CASs are mandated to fulfill the following functions, as outlined in section 35 of the CYFSA:

"35 (1) The functions of a children's aid society are to,

(a) investigate allegations or evidence that children may be in need of protection;

(b) protect children where necessary;

(c) provide guidance, counselling and other services to families for protecting children or for the prevention of circumstances requiring the protection of children;

(d) provide care for children assigned or committed to its care under this Act;" (CYFSA, 2017)

Part V of the CYFSA: Child Protection

Part V of the CYFSA outlines legislated responsibility for responding to a child suspected of being in need of protection. This Act designates the forms of child abuse and neglect and prescribes the roles and responsibilities of the child protection worker, including setting forth the rules of procedure and legislative authority to act. Section 74 [1] mandates the child protection worker for the purposes of section 81 of the Act (CYFSA, 2017). Section 81 [1] mandates that "a society may apply to the courts to determine whether a child is in need of protection" and subsections 2 to 13 define the procedures for undertaking a child protection investigation (CYFSA, 2017).

When is a Child in Need of Protection in Ontario?

Under Part V of the CYFSA, section 74 (2), the Act lists 17 different grounds for finding a child in need of protection. These include that the child has suffered or is likely to suffer physical harm inflicted by the person having charge of the child, the child has suffered emotional harm resulting from the actions, failure to act or neglect on the part of the person having charge of the child, and the child suffers from a mental, emotional or developmental condition that could seriously impair the child's development and the person having charge of the child does not provide treatment (CYFSA, 2017). Section 74(2) is reproduced fully in Appendix A.

In addition, section 74(3) directs that in order to make "a determination in the best interests of the child", certain criteria need to be considered (CYFSA, 2017). This includes the child's views and wishes; in the case of a First Nations, Inuit and Métis child, considering the importance of preserving cultural identity and connection to

community, and other relevant factors of the case such as the child's physical, mental and emotional needs, the child's cultural and linguistic heritage, the importance for the child's development of a positive relationship with a parent and a secure place as a member of a family, and the importance of continuity in the child's care (CYFSA, 2017). Section 74(3) is reproduced fully in Appendix A.

Mandated Services and Their Duty to Protect

The mandate of a CAS is derived from the Child, Youth and Family Services Act (2017) and a variety of tools are deployed by child protection workers to meet their mandate, as per their training.

Eligibility Spectrum

Ontario's Eligibility Spectrum is a mandated front-end, gate-keeping tool that assists Ontario child protection workers in making consistent and accurate decisions on whether a referral involving a family and child meets eligibility criteria. The Eligibility Spectrum is based on the legislation that is informed by current extant literature and best service practices. The most recent revisions to the Eligibility Spectrum were in 2021, with the 2007 Eligibility Spectrum being the tool in use at the time of this child's death. For a history of the development of the tool, see Appendix B.

The Ontario Child Protection Standards

The Ontario Child Protection Standards (Ministry of Children and Youth Services, 2016), hereinafter called The Standards, direct workers to detail the type of maltreatment occurring and set out the expectations that must be met when there is a referral for a child protection investigation. The first five standards must be completed in all cases, for situations with or without an open child protection file. Investigations can be traditional or customized, and the worker must determine the appropriate type of investigation for the individual situation. Standard 1 outlines the key factors to consider when determining the appropriate response to a referral. Standard 2 outlines the appropriate type of investigation. Standard 3 outlines the requirement for the child protection worker to undertake a safety assessment in accordance with the safety assessment tool in the Ontario Child Protection Tools

manual when conducting a family-based investigation. Standard 4 provides an overview of the child protection worker's responsibility to conduct a risk assessment and the responsibility to share that assessment with the family. Standard 5 outlines the process that should mark the conclusion of the child protection investigation. For additional detail on each of the Standards, see Appendix C.

Contemporaneous Case Notes

The minimum standard for contemporaneous case notes requires that all case records include, at minimum, the following: a) date and time of contact; b) Method of contact; c) Name of individuals involved; d) Significant events, discussions and observations related to the particular contact; e) Name of author and date of notation. Following the child protection investigation, the worker should compose the following: 1) a summary of what they believe occurred in relation to the original alleged or new child protection concerns; 2) an analysis of the safety assessment, the strengths and protection factors as well as all other relevant information; 3) documentation of any police charges and any child welfare court activity; 4) the rationale for the verification decision for each child protection concern; and 5) the rationale for determining if the child was in need of protection.[3]

Training of Child Protection Workers

The Ontario Association of Children's Aid Societies (OACAS) delivers the pre-service training for Ontario child protection workers. The OACAS is an advocacy body, comprised of fee-paying CAS agency members. Not all agencies designated under the Act are members of the OACAS. They deliver, with funding provided by transfer payment from the Ontario government, a series of eight modules of content. Course five of the Reimagined Child Welfare Pathway to Authorization [CWP]: child development and maltreatment training, is considered for the purposes of this review, and it is delivered as a mix of e-learning and in-class instruction. The in-class section provides concrete and experiential guidance to workers on identifying internalizing and externalizing behaviours exhibited by young children in the context of IPV post-

[3] See recommendation 4

separation, and through the use of coercive control when exercising parenting time. These in-class sessions include content on child development and maltreatment, recognizing trauma in children and families, building and strengthening attachment, supporting the protection and well-being of families and working with developmental screens.

Emotional abuse and exposure to IPV are two forms of maltreatment discussed within this basic initial training. The training describes how children involved with IPV will see, hear and experience these behaviours, and how this can have a negative impact on their well-being. A 1998 National Clearinghouse on Family Violence (NCFV) handbook is cited to identify a range of impacts on children and youth exposed to IPV. Replicated within the curriculum is a table listing bullet points describing children's symptoms exhibited at different developmental stages as a result of exposure to IPV, such as infants experiencing failure to thrive and disruption to their eating and sleeping routines, and preschool-aged children experiencing effects such as "aggressive acts, clinging, anxiety, cruelty to animals, destruction of property, [and] PTSD symptoms" (NCFV, 1998, as cited in OACAS, n.d., Section 7: Intimate Partner Violence). Parenting behaviours related to the "abusive partner as parent", are listed to include examples such as: "controlling of child, partner/ex-partner and extended family relations, using child as a pawn by which to punish/control or communicate with partner, sense of entitlement and lacking empathy for child, partner".

The curriculum slide-deck encourages workers to think critically and consider how the age of the child might influence the impacts from IPV, with further prompting for the worker to consider the effects of maltreatment on the child's developmental milestones (physical, cognitive, and emotional).[4]

[4] See recommendations 6, 10, 14 and 15

Emotional Abuse and Neglect

The training distinguishes emotional neglect from emotional abuse, with neglect being a passive form of child maltreatment and an act of omission such as not requiring treatment for a treatable disease, and emotional abuse being an active form of child maltreatment requiring an act of commission such as a caregiver acting in such a way that the child requires treatment as a result of emotional distress. The training references Garbarino et al.'s (1978,1986) typology of forms of emotional maltreatment

1. **Rejecting/Spurning**: Constant criticism, refusal to show affection to child

2. **Isolating**: Keeping child from social interactions, family and friends

3. **Ignoring**: Not responding to child's behaviours, achievements

4. **Terrorizing**: Threatening child with abandonment or harm, climate of fear

5. **Exploiting/Corrupting**: Encourages child involvement in criminal, aggressive activities (Garbarino, 1978, 1986, as cited in OACAS, n.d.).

As is discussed elsewhere in this report, cursory training is provided about exposure to IPV and the impacts of this exposure on the child's development. Citing the Ontario Incidence Study of Reported Child Abuse and Neglect – 2013 by Fallon et al. (2015), the training documentation informs that emotional maltreatment comprises 13% of reports and exposure to IPV is evident in 48% of all reports. These observed rates are likely a function of the mandatory reporting by the police when they encounter children in the context of IPV. Stated again, just under half of the verified child abuse and neglect in Ontario emerges in the context of IPV. Calls from advocates stating that IPV is a crisis for women are emerging, and the evidence has long demonstrated that this crisis drives the need for child protection services.

Coercive Control in Post-Separation Parenting

The base training curriculum provided to child protection workers related to IPV, post-separation, and the role of coercive control in high conflict post-separation parenting situations needs modernizing. The training lists six examples of parenting behaviours that can be demonstrated in the context of IPV such as: “controlling of the child, partner/ex-partner and extended family; using child as a pawn by which to punish/control or communicate with partner; sense of entitlement; lacking in empathy for child, parent; rigid, authoritarian, creating fear, bullying; and demonstrating no/poor boundaries” (Jaffe et al., 2008, as cited in OACAS, n.d. Section 7: Intimate Partner Violence).

The Link Between IPV and Child Protection

What Is Intimate Partner Violence?

Across all cultures and economic structures, IPV is known to exist. It includes physical and psychological behaviours that are intended to control and dominate the victim. IPV “refers to behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, and psychological abuse and controlling behaviours” (World Health Organization, 2014, Introduction, para. 2). IPV can take many forms such as physical assault or threats of assault, as well as various forms of psychological violence such as derailing finances, threatening to harm themselves or others, and other behaviours intended to intimidate, destabilize and control the victim. Marginalized individuals are disproportionately impacted, and it is primarily a gender-based form of violence. It is a form of violence that disproportionately impacts women, as they experience the majority of instances of IPV [79%] (Conroy et al., 2019).

Coercive Control as a Form and Feature of IPV

Dutton and Goodman (2005) identified coercive control as a form of IPV that “is a dynamic process linking a demand with a credible threatened negative consequence for non-compliance” (Dutton & Goodman, 2005, p. 746-747). It is designed to punish, hurt, or control a victim; its effects are cumulative rather than incident-specific; and it frequently results in severe injury or death (Stark, 2007, p. 369). They note that there are eight distinct domains where coercive and controlling behaviours are applied and these include: 1) personal appearance/ activities; 2) family, social and support systems, 3) household; 4) work and economic resources; 5) health; 6) intimate / sexual relationship; 7) legal/ immigration, and 8) children. In the context of children, for instance, the victim can be threatened with reports to child protection services (Dutton & Goodman, 2005, p. 747).

Is IPV a Form of Child Maltreatment?

In 1994 and 1995, Ontario was rocked by a series of deaths of young children, all occurring while these children were in the care of or receiving service by a children's aid society, and the public demanded answers. Over the course of this two-year period, one hundred children receiving services from an Ontario CAS had died, and fifty-nine of these children were living with their family and receiving either investigative or supportive services at the time of their death. The Ontario Child Mortality Task Force was charged with understanding the gaps in knowledge and service and to make recommendations in order to better protect children (Office of the Chief Coroner of Ontario, 1997). As will be discussed shortly, the roots of CPIN can be found in the resultant recommendations, and, additionally, two recommendations are directly relevant to this current review. The Task Force recommended three legislative amendments, including "protection for those children who witness family violence" (p. 32), encouraging early and decisive intervention with very young children under five, as well as urging "the development of a comprehensive pediatric screening mechanism for high-risk infants at birth" (p. 31).

Exposure to IPV is not currently a legislated form of child abuse in Ontario, though it is

generally recognized as an Adverse Childhood Experience (ACE) (Anda et al., 2006; Bogat et al., 2006). Evidence indicates significant risks to child development as a result of experiencing IPV and that mediating these risks requires early and sustained intervention (Amato & Afifi, 2006; Carpenter & Stacks, 2009). The stressors on child development include behavioural, emotional, physical, cognitive, and social impacts (Bair-Merritt, Blackstone & Feudtner, 2006; Carlson, 2000).

Psychological violence accounts for the majority of IPV that children are exposed to (Fong et al., 2019; Manitoba Advocate for Children and Youth,2022). There can be short and long-term impacts ranging from minimum to extreme as a result of exposure to IPV (Tutty & Nixon, 2020). Contextual factors such as the age of the child, the child's individual protective factors, gender, access to support and relationship with both parents can impact outcomes. Younger children are over-represented in cases of IPV. This is for a variety of reasons including the demands placed on caregivers in these early stages of developmental vulnerability (Miller & McCaw, 2019; Taylor et al., 2009). Exposure to chronic stress increases the risk of chronic health problems, has impacts on IQ and educational achievement, disrupts emotional regulation, and increases the risk for intergenerational violence and trauma symptoms (Kim et al., 2013; Koenen et al., 2003; Muzychenko et al., 2018; Taylor et al., 2009; Tiedt & Brown, 2014). Externalizing behaviours such as behavioural dysregulation are associated with IPV and findings have shown that "[e]ven when children and mothers are separated from batterers, the damaging aftereffects of IPV tend to persist. Findings from longitudinal studies have also suggested a causal role of IPV in the development of child conduct problems" (Anda, et al., 2006; Fong et al., 2019, p. 150; Jouriles et al., 2014). Systemic family intervention is often required in addition to behavioural interventions such as coaching, anger management or negotiated co-parenting plans, and also, direct intervention to support children's own agency and coping.

Amendments to the Divorce Act introduced in March 2021 demonstrate judicial recognition that coercive control is a dangerous form of violence (Lux & Gill, 2021). These amendments, now enshrined in law, describe both direct and indirect IPV, and define coercive and controlling behaviours as "a pattern of emotional abusive

intimidation, coercion, and control, often combined with physical violence" (Divorce Act, 1985). It is noted that there are four types of IPV: 1) coercive and controlling violence; 2) violent resistance; 3) situational [or common] couple violence; and 4) Separation – instigated violence. When considering parenting time and decision-making responsibility, the family court is directed to assess these factors, along with determining the best interests of the child.[5]

[5] See recommendations 2,3, 8, 10 and 14

Themes Emerging from the Review

The Child's Right to be Protected

What is most striking to the reviewer reading the child protection record, and the court transcript, is the lack of discussion about the needs and interests of this very young child. In fact, a Justice of the court noted the same. "THE COURT: You know, one thing I never heard in the submissions is anything about [the child]. I think it is a real shame".

The protection needs of the child do not appear to be paramount, her well-being does not appear to have been scrutinized, and the best interest assessment seems to be deferred to the courts. The courts undoubtedly were charged with determining access rights / parenting time, and the judges were obligated to consider the child's best interests, protection and well-being, but the CAS workers too, independently, and at each decision-making point, needed to hold these paramount considerations at the center of case planning, risk appraisal and service delivery.

Review to Continuously Appraise Risk

The child protection record did not outline a cumulative review of the risk to the child as a result of the chronic conflict. The child protection workers were faced with appraising the need to protect a child where the family was in a prolonged court case. They heard conflicting stories, received repeated allegations, reviewed inconclusive assessment reports and engaged in continuous case contact, yet, the totality of the case does not appear to be appraised until the completion of the assessment just prior to her death. It was as if the psychological treatment provided to the child was believed to have been sufficient to alleviate the risk faced by a child under the age of five, who was subject of a prolonged parenting dispute and was experiencing escalating parental conflict, increased demands on her primary caregivers with the birth of a new child and the introduction of a step-parent. While not all children experience negative impacts from exposure to IPV, research demonstrates that the risks are significant and mediating these risks requires early and consistent intervention (Callaghan et al., 2018).

Here was a very young child, demonstrating physical and emotional indicators of

distress and experiencing continued conflict, and ongoing distress, despite psychotherapeutic intervention. Although the community disposition of psychotherapeutic intervention is understandable, it did little to reduce the conflict that she was exposed to or provide supportive care to the child in order to manage the conflict that arose around access / parenting time visits with her father. Had there been earlier intervention to support the success of access visits/parenting time, by providing supervised access, and/or a children's worker to enable direct support to the child, she might have been better supported in her community. The provision of voluntary services is always preferable, but if the CAS was unclear about the root of the conflict, they might have considered seeking a supervision order. Granted that the family had several protective factors, and the workers were faced with conflicting case reports, however, it does not appear that the child protection workers took the sufficient steps necessary to support the child in managing the conflict, such that intervention was able to reduce the risk of emotional harm.

Given that parenting time had repeatedly been a source of conflict and distress, including necessitating the involvement of police, it is surprising that an order for supervised access was not contemplated as a potential mitigator of this risk. Even if the disposition of community support was the determination, the CAS needed to ensure that the community supports were sufficiently able to reduce the risk of harm to the child.

Safety Planning Directly with Child

There does not appear to have been direct safety planning conducted with the child. All children have a voice even those that are nonverbal. Anyone who has ever spent time with an infant is aware that even young children are effective communicators. Children are active communicators in their life space upon their arrival and this capacity evolves and develops throughout their maturation. Children in the context of IPV also deploy agency in addition to voice and both can be detected as being deployed very early in situations of adversity, coercive control, and IPV (Callaghan et al., 2018)

The impact on the child, and her emotional distress, resulting from prolonged conflict needed to be assessed as a form of child abuse, and while there are instances of

verified child maltreatment, including moderate appraisal of risk to the child, the cumulative impact of this exposure does not appear to be considered until shortly before her death, and after one of the rare private meetings with the child. In a review of the research on children's exposure to coercive and controlling behaviours, Stark and Hester (2018) conclude that there is evidence that:

> The resulting "child abuse" is both direct, in that children report feeling existential vulnerability ("No one can protect me"), and a form of "tangential spouse abuse," whose ultimate test is the mother's coming to heel. Children may appear to be passive instruments of the abuser's control, as in a custody fight, or, at the other extreme, a child may openly align with the abusive parent or join his coercive control (p. 98).

The child is the primary service recipient, with entitlements to protection and full consideration of their entitlements under the mandate assigned to the CAS, and in this case, the child's protection needs did not seem to drive case planning and service delivery.

During a parenting time visit, the child was not returned at the agreed time. The step-parent sought a wellness check for the child and the police attended the father's home. The police did not meet with the child, or, since the child was said to be sleeping, observe the child individually, instead, they accepted a photo on a phone shown to them by the father. The officer fulfilled their duty to report by reporting to the CAS his concern about the risk of emotional harm to the child resulting from these types of calls.

During an unannounced visit to the mother's home, and in a private interview, the worker noted that the child appeared "to feel more comfortable at mom's". The child shared that she received more support with her sleeping routines at her mother's house. The child reported to her child protection worker that she "would often want to call mom when at dad's house but dad would mute the calls and make excuses, and many birthday parties he would not allow her to go and no play date [that] his house only at Moms". There is no notation about how the child's concerns were addressed.

The child protection worker reports being told that when the child came back home from dads, her behaviour would change. Included in this case documentation is a direct quotation, seemingly from the mother, referencing that the child's behaviour "it’s night and day contrast, takes a day to get back. She will say her love is broken”.

In a phone call with her mother, the child protection worker records that that child “says she doesn’t sleep at dad’s house, and no one helps her”. There does not appear to be a follow-up with the child about the concerns that she was raising, or a renewed risk appraisal, despite the vulnerability factor of the child being less than five years of age.

The CAS consults the child’s play therapist, a psychologist, who notes that the child “is barely 4 years old, [and] has [a] tough time being away from mom from [sic] extended periods of time”. The psychologist expresses concern about the child's difficulties with self-regulation when she returns from visits with her father and wonders if sufficient communication is maintained between the child and her mother during his access /parenting time visits. While this is not a direct communication with the child, the child's advocate was expressing concern and this does not appear to generate case activity such as a renewed risk assessment, an individual meeting with the child, or safety planning with the child and her family.

Five days before her death in a private meeting with the child, the child expresses a number of concerns about her exposure to the parental conflict. The child protection worker makes a notation that she asked the child about lying and then followed-up by reminding the child that she had mentioned dad lying and the child responded by saying, "don’t tell him she said that. He will get really mad”. This meeting prompted the child protection worker to contact the supervisor to seek permission to add another component to the investigation: the emotional harm caused to child due to exposure to conflict.

Two days prior to her death, the police were called to attend during a parenting time / access visit transfer, when the father refused to release the child into the care of the stepfather. Despite the presence of a new stressor that comes from the arrival of a new sibling, and with due consideration of the exposure of the child to the increasing conflict with the stepfather, there does not appear to be an independent meeting with the child.

The child protection worker develops a safety plan with the mother to ensure that the stepfather would not be doing further exchanges and provides a recommendation to call emergency-after-hours-services (EAHS) should there be further problems. Despite the child being directly involved in the conflict, there does not seem to be any safety planning conducted directly with the child. There does not seem to be recognition that there is a new infant in the home, or the challenges this might create when undertaking access transfers/parenting time.

Appraisal of the Risk in the Context of Post-Separation Conflict and Coercive Control

The Child Development and Maltreatment module outlines five forms of emotional maltreatment. Recognition of how emotional abuse featured in this child's life, including isolating, ignoring and terrorizing are not described as part of the case risk assessment.

Documenting the experience of the child might have allowed for the articulation of this harm. For example, repeated reports about the refusal to allow the child to communicate with the mother were found within the court documents and reported to the child protection worker by the child's play therapist and mother. These reports were apparently not recorded as examples of emotional maltreatment in the form of isolating.

Shortly before her death, police were called during the return of the child from an access visit / parenting time. The scene that unfolded during the transfer of the child, is one that has a child with the additional vulnerability of the arrival of a new sibling, yet the record does not appear to reflect this as potentially terrorizing.

The child repeatedly informs her child protection worker that sleep routines are concerning to her when she is at her father's; however, her concerns were not contemplated as potential child maltreatment. Granted that it may simply be that mom and dad have different sleep routines, but in this context, the child raised a concern, and the case notes do not seem to reflect further exploration with the child directly. The child protection workers knew that the child was having many vague illnesses, and this should have alerted them to consider internalization, and the child's play therapist was expressing alarm over her anger and dysregulation post-access visit/parenting time,

pointing to externalization.

Callaghan et al. (2018) note that the framing of the child as witnessing, or simply being exposed to IPV, ignores both the child's direct victimization and the child's own agency deployed to adapt to the situation. They contend that:

> [a] shift to recognize children as equal victims in the crime of domestic violence and abuse has two important implications—It requires that we listen to children who experience domestic violence and abuse, and it creates space to recognize their own creative and agentic strategies in response to abuse and control within the family. It opens a different discursive space in which the child is recognized as being as important as the adult antagonists in our responses to domestic violence and abuse (p. 1572).

Elements of Coercive Control in the Present Case

Coercive control is a form of IPV that enacts psychological harm, and in the context of a parent, can involve young people as key targets. Young people have agency, even in the face of adversity, perhaps even especially, out of necessity, when facing adversity, and even at very young ages. However, we do know that very young children, by virtue of their physical and material dependency, are at heightened risk, due to the developmental norm of having less expectation of agency and less independence and capacity to exercise it (Callaghan et al., 2018). This does not however mean that very young children do not exercise agency in the context of IPV, however, given their developmental immaturity, child protection workers must consider very young children's vulnerability when appraising risk.

The role of the child protection workers is to describe the situation that places the young person at risk and articulate the harm that might result from it, and then appraise this risk based on the child's well-being, best interests, and protection needs. This is their mandate as outlined in the paramount purposes of the CYFSA. To do this, in this particular case, the workers needed to be able to describe the coercive control that featured in this situation.

Several researchers have described various forms of coercive control that might be observed, including as it features in parenting time post-separation (Katz et al., 2020; Stark & Hester, 2019). There did not appear to be an articulation of various forms of coercive control, perhaps a result of a lack of language to describe the different forms that a child protection worker might describe when observing them during the course of an investigation.

Withholding the Child

There were at least five instances where the child was unexpectedly removed from the care of the custodial parent, or where she was not returned at the expected time. There does not appear to be a consideration of the impact of these unplanned separations, or of the potential distress for the child or her caregivers, and her prolonged exposure to these repeated behaviours.

Priming the child to make statements

Recordings were submitted to the child protection worker, where the child seems to be coached to make statements. These recordings do not seem to be recognized as a form of coercive control, and seemingly the impact on the child is not assessed in terms of the risk of emotional harm that results from being primed to make statements.

Isolating the child

The child herself raised concerns with the child protection worker about not being able to contact her mother. She confided to the worker that she believed her father wanted to keep her to himself. There did not appear to be a response to the child about the concerns that she was raising, or in response to her psychotherapist raising similar concerns.

False allegations

There were several false allegations, in the context of dishonesty. The father accused the mother of having Munchausen's Syndrome and accused the stepfather of child abuse. Trocmé and Bala (2005) discuss the need for child protection workers to be alert to false allegations of child abuse and neglect when parents separate and the need to be diligent when assessing risk.

Non-Compliance with Access Orders

There were three days of supervised access ordered by the court during the course of the custody hearing. The CAS did not seek either voluntary or court-ordered supervision. At the time of the child's death, the mother was seeking to limit the father's access visits and the CAS was in the process of putting together a report for the judge about their appraisal of the risk to the child.

Weaponizing of Services and Coercive Control of Professionals

The father appears to engage the pediatrician about a visit, controlling the narrative and directly referencing the CAS involvement, and soliciting him to observe the interaction among the child, her father, and her paternal grandmother and faxes this to the CAS, that is used in their decision making. The police have repeated involvement in access /parenting time visits. Medical care is contested. The worker at the child's nursery school emailed the CAS about access/parenting time rights and the notes quote her as saying "He was very aggressive" and later was reported as saying that he "threatened to bring police if I did not release [the child] to him".

Technology enabled coercive control

A supervisor of the CAS found it necessary to direct that an email be sent to the father to let him know that if he records the worker without consent then the worker "will not attend his house for home visit". Certainly, the sheer volume of communication from the father was enabled by technology.

Procedural and Administrative Matters

The father asked that the file be transferred to a nondenominational CAS, and at a later point while, raising Indigeneity, involved an Indigenous Child and Family Well-being Agency. The case is remarkable by the prolonged and repeated procedural motions regarding custody and access. In Canada, a very small number of cases are addressed by the courts and a much smaller number have multiple hearings. Custody and access cases [parenting time] comprise 19% of active Family Court cases in Canada. Family law litigants represent themselves in 58% of the situations (Burns, 2021). The Justice makes note of this commenting: “Your case is an outlier for us in terms of the number of times you have to come into court, the disagreeable nature, the amounts of costs”.

In view of these instances of coercive control, had the child protection worker undertaken the task of describing the coercive control that the child experienced, they might have been more readily able to see the totality of the case. Having a language to describe the behaviours that created risk of emotional harm, might have heightened the workers sense of this child’s vulnerability. It is also important to recognize that being able to describe coercive control is not sufficient to meet the threshold of the CYFSA to do that, there needs to be evidence of distress, such as anxiety and dysregulation, as was demonstrated by the child in this case.

Lethality Risk Factors

Child protection Standard 1 notes that the child protection worker must engage in a continuous review of emerging evidence in order to accurately appraise the risks for lethality. The Office of the Chief Coroner of Ontario released the 2012 Annual Report of the Domestic Violence Review Committee in February 2014. Included in the report are evidence-informed risk factors for lethality. These 39 factors can be used to appraise the risk of a lethal outcome. The measure is not deterministic, rather it serves to highlight red flags related to lethal outcomes. The scale asks the reviewer to determine if the available evidence suggests that the risk factor was absent, present, or if it is unknown.

Relevant to this young child's situation, the following factors were present in the documentation:

1. History of domestic violence
2. Prior attempts to isolate the victim
3. Prior hostage taking and/or forcible confinement
4. Child custody or access disputes
5. Prior destruction or deprivation of the victim's property
6. Prior assault on victim while pregnant
7. Perpetrator was abused and/or witnessed domestic violence as a child
8. Obsessive behaviour displayed by perpetrator
9. Prescence of stepchildren in the home
10. Extreme minimization and/or denial of spousal assault history
11. Actual or pending separation
12. Other mental health or psychiatric problems – perpetrator
13. New partner in victim's life
14. Failure to comply with authority – perpetrator
15. Victim's intuitive sense of fear of perpetrator

There were additional sources of stress including that the father was concerned about losing parenting time in an imminent court hearing, his business was failing, his ex-wife had a new partner and they just had a child. In addition, the new partner was a family law lawyer and knowledgeable about matters of custody and access. The presence of coercive and controlling behaviours are associated with lethality. In this regard, Stark (2007) points out, "two factors unique to abusive relationships also predicted fatality: whether the couple had separated after living together, and whether an abuser was highly controlling in addition to being violent" (p. 277).

Additional Structural Observations

CPIN Case Views

The Child Protection Information System (CPIN) is a province-wide information system that followed recommendations from the 2014 Jeffery Baldwin jury verdict. Jeffery Baldwin was a young child who died while being provided service by an Ontario CAS. Of the 103 recommendations that came from the verdict, the first recommendation was the creation of a province-wide information system that came to be called the Child Protection Information System.

CPIN is a province-wide, customized IT system that began the modernization of child welfare by introducing a consistent approach to collecting information across the province. It tracks information at the 50 provincial CASs in Ontario on a broader scale than ever before. CPIN includes information collected at intake as well as information about children in care, legal proceedings, foster care, group home care, and adoption. In addition, case file and financial information are now completely integrated so that, at a glance, an agency can determine how much is spent on a given child or family. Staff are assigned CPIN roles which limit the data and information accessed. Protection of privacy is a key concern. All CASs were to have on boarded onto CPIN between 2015 to 2020.

CPIN records are not presented in a way that provides an easy way to access case summary information, such as basic descriptive data, date of last risk assessment, safety plan details, or other markers that would assist the child protection workers in quickly understanding the child's situation. The review team transcribed all CPIN records, using R Studio to examine the records in a detailed manner, and noted the challenging format CPIN produces, in terms of providing a quick summary of the case involvement, basic descriptive data or keeping track of timeliness in case activity. The framing of events from the vantage point of the child and their exposure to violence is not apparent in the CPIN and documents. For example, the review team looked for the articulation of the circumstances of the exposure to violence and the impact of this exposure on the child such as: screening for internalizing and externalizing behaviours, private meetings with the child to further elicit their vantage point, or safety planning

conducted privately, and directly with the child. Such filters would assist agencies in ensuring that standards are met, and that details of cases can be easily gathered.[6]

Learning From a Child Death Review

The internal child death review conducted by the lead agency identified the need for improved training around Intimate Partner Violence (IPV). A close assessment of compliance to standards might have directed the reviewer to dig more deeply and review details of the case management and in doing so, might have prompted the agency to retool its capacity to appraise high conflict access/parenting time in relation to coercive and controlling parenting behaviours. The internal child death review process is intended to provide an opportunity for a more rigorous internal review and audit of a case files to learn from the tragedy and enhance services on a go-forward basis. In the present case, however, it is unfortunate that this opportunity was not utilized to the full extent possible.[7]

Conduct of Service Providers Post-Death

The family reports that post-death, a child protection worker communicated in a manner that requires further review. In addition, the pediatrician sent a notice to the patient. These encounters point to a need for further professional development around communicating difficult and upsetting news, specifically in the context of child welfare and child death.[8]

[6] See recommendation 7
[7] See recommendations 1 and 3
[8] See recommendation 5

Summary

The mandate of the CAS is to serve children, that is, the CAS exists to protect children from the legislatively defined factors that place their development and well-being at risk. It is one of few government funded services with a legislative mandate exclusive to young people. The service mandate is derived from "(1) The paramount purpose of this Act is to promote the best interests, protection and well-being of children, and as such, services should focus on the protective needs of the young people that they serve. Young people are active agents, not objects placed at the center of a family, or a service.

Notably absent in this case is the voice and perspective of the child. The child's concerns do not seem to drive service, nor do they seem to be engaged in safety planning, and this is surprising given that the mandate of the service is to protect the child.

Educators expressed concerns about the conflict that they were witnessing. There were two reports consistent with section 125 of the Act (Police Officer and Early Childhood Educator), that provides for the enhanced duty to report for those in professional roles. The police reported in response to concerns about the well-being of the child, making a report that the conflict over access visits might harm the child, however, the police did not independently observe the child, to assure the safety and well-being of the child. Conflict was evident during encounters with physicians, and a school principal expressed concern for the well-being of children in the school, but there was no report of concern to the CAS.[9]

Here we have examples of a child under 5 with known exposure to IPV, repeated examples of her father lying to the court and not complying with the orders of the court and ongoing post-separation conflict lasting many years, and yet, the risk profile outlined does not appear to bring forward the cumulative risk, nor the prolonged and multiform exposure that the child was experiencing (exposure to family conflict, coercion, unexpected separations and post-separation family conflict). Despite the child

[9] See recommendations 9, 11, 12 and 13

requiring treatment for distress, and self-regulation regarding visits, there is no direct intervention to reduce the conflict, thus reducing the risk the child was facing.

The need to be more vigilant with a child under 5 is necessary due to the child's developmental vulnerability and because of the absence of eyes-on-the-child, that begins with the socialization of the child in school, and in community activities that serve to reduce the risks that result from isolation. In this situation, she was seen by numerous professionals, some of whom expressed concerns about the child, and about her father. This was not a situation of a child unseen by potential advocates, this was a child seen by numerous advocates, yet unheard, with few raising concern about the lengthy and multiform conflict that this young child was exposed to.

The child protection workers may not have been able to prevent the death, but they did have evidence of emotional harm, and little was done by way of supporting the child directly with the challenging situations that she was facing during access visits. The ability to deflect service to the community, seems to have resulted in the child protection workers assigned to the case being unable to continuously appraise the risks to this young person and see her distress.

Recommendations

To the lead Children's Aid Society

1. Revisit the literature related to the value of conducting child death reviews and develop a community of practice that will inform the orientation to any future internal child death reviews.
2. Conduct agency-wide training on IPV with a specific focus on the context of post-separation parenting time (custody/ access).
3. Review and report back to MCCSS on a review of internal investigation practices to ensure alignment with The Standards and demonstrate a clear alignment to the paramount purposes of the Child, Youth and Family Services Act. Specifically: ensuring that the voice of the child directs service planning, that practices are directed by service standards, and that there is an articulation of the alleged or suspected harm[s], with a clear description of if, and how, this may be impacting on the best interest, well-being and protection needs of the child.
4. Set internal standards of practice for case recording to ensure that the details of compliance with standards are articulated within the case note.
5. Conduct a review of the communications with the family post-death and make recommendations for best practices for communicating post-death.

To the Ministry of Children, Community and Social Services

6. Introduce regulations that set standards for the pre-service training of child protection workers, including ensuring the curriculum undergoes regular review, expert oversight and that it is maintained in a current form.
7. Develop case summary views in CPIN for child protection investigation work including options for cumulative summaries.

8. Revise the CYFSA to include involvement in IPV that causes distress to the child and places their well-being at risk as grounds for a child to be deemed in need of protection.

9. MCCSS to take the lead to fund training on professionals and officials' duty to report and make it available to all relevant professional and regulatory bodies and private school authorities. MCCSS should coordinate with all relevant regulatory bodies and private school authorities.

To the Ministry of the Attorney General

10. Liaise with relevant Ministries to develop curriculum consistent with the new amendments to the Divorce Act and the linkage to IPV and child protection with a specific focus on understanding policy, legislation, and practice-related issues.

To the Ministry of Education

11. Investigate current knowledge in order to develop training to ensure that all private schools and programs operating under the Education Act 1990, and the Child Care and Early Years Act 2014, routinely undertake training regarding the enhanced duty to report.

To the College of Psychologists of Ontario, the Ontario College of Social Workers and Social Service Workers, and the College of Registered Psychotherapists of Ontario and the Ontario College of Teachers

12. Issue a practice directive reminding of the enhanced duty to report child abuse and neglect.

13. Ensure regulated professionals review training on their Duty to Report on a biannual basis.

To the College of Physicians and Surgeons of Ontario

14. Facilitate the creation of professional development about emotional harm and coercive control.

To the Ontario Association of Children's Aid Societies

15. Modernize the pre-service training and develop content in the context of intimate partner violence current/ex-partners and coercive control in the context of custody and access.

16. Develop a process of review for the pre-service curriculum that is offered that includes internal and external peer review and periodic review for currency.

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Appendix A: Child, Youth and Family Services Act, 2017

Paramount purpose

1 (1) The paramount purpose of this Act is to promote the best interests, protection and well-being of children.

Other purposes

(2) The additional purposes of this Act, so long as they are consistent with the best interests, protection and well-being of children, are to recognize the following:

1. While parents may need help in caring for their children, that help should give support to the autonomy and integrity of the family unit and, wherever possible, be provided on the basis of mutual consent.
2. The least disruptive course of action that is available and is appropriate in a particular case to help a child, including the provision of prevention services, early intervention services and community support services, should be considered.
3. Services to children and young persons should be provided in a manner that,

i. respects a child's or young person's need for continuity of care and for stable relationships within a family and cultural environment,

ii. takes into account physical, emotional, spiritual, mental and developmental needs and differences among children and young persons,

iii. takes into account a child's or young person's race, ancestry, place of origin, colour, ethnic origin, citizenship, family diversity, disability, creed, sex, sexual orientation, gender identity and gender expression,

iv. takes into account a child's or young person's cultural and linguistic needs,

v. provides early assessment, planning and decision-making to achieve permanent plans for children and young persons in accordance with their best interests, and

vi. includes the participation of a child or young person, the child's or young person's parents and relatives and the members of the child's or young person's extended family and community, where appropriate.

Child in need of protection

74(2) A child is in need of protection where,

(a) the child has suffered physical harm, inflicted by the person having charge of the child or caused by or resulting from that person's,

(i) failure to adequately care for, provide for, supervise or protect the child, or

(ii) pattern of neglect in caring for, providing for, supervising or protecting the child;

(b) there is a risk that the child is likely to suffer physical harm inflicted by the person having charge of the child or caused by or resulting from that person's,

(i) failure to adequately care for, provide for, supervise or protect the child, or

(ii) pattern of neglect in caring for, providing for, supervising or protecting the child;

(c) the child has been sexually abused or sexually exploited, by the person having charge of the child or by another person where the person having charge of the child knows or should know of the possibility of sexual abuse or sexual exploitation and fails to protect the child;

(d) there is a risk that the child is likely to be sexually abused or sexually exploited as described in clause (c);

(d.1) the child has been sexually exploited as a result of being subjected to child sex trafficking;

(d.2) there is a risk that the child is likely to be sexually exploited as a result of being subjected to child sex trafficking;

(e) the child requires treatment to cure, prevent or alleviate physical harm or suffering and the child's parent or the person having charge of the child does not provide the treatment or access to the treatment, or, where the child is incapable of consenting to the treatment under the Health Care Consent Act, 1996 and the parent is a substitute decision-maker for the child, the parent refuses or is unavailable or unable to consent to the treatment on the child's behalf;

(f) the child has suffered emotional harm, demonstrated by serious,

(i) anxiety,

(ii) depression,

(iii) withdrawal,

(iv) self-destructive or aggressive behaviour, or

(v) delayed development,

and there are reasonable grounds to believe that the emotional harm

suffered by the child results from the actions, failure to act or pattern of neglect on the part of the child's parent or the person having charge of the child;

(g) the child has suffered emotional harm of the kind described in subclause (f) (i), (ii), (iii), (iv) or (v) and the child's parent or the person having charge of the child does not provide services or treatment or access to services or treatment, or, where the child is incapable of consenting to treatment under the Health Care Consent Act, 1996, refuses or is unavailable or unable to consent to the treatment to remedy or alleviate the harm;

(h) there is a risk that the child is likely to suffer emotional harm of the kind described in subclause (f) (i), (ii), (iii), (iv) or (v) resulting from the actions, failure to act or pattern of neglect on the part of the child's parent or the person having charge of the child;

(i) there is a risk that the child is likely to suffer emotional harm of the kind described in subclause (f) (i), (ii), (iii), (iv) or (v) and that the child's parent or the person having charge of the child does not provide services or treatment or access to services or treatment, or, where the child is incapable of consenting to treatment under the Health Care Consent Act, 1996, refuses or is unavailable or unable to consent to treatment to prevent the harm;

(j) the child suffers from a mental, emotional or developmental condition that, if not remedied, could seriously impair the child's development and the child's parent or the person having charge of the child does not provide treatment or access to treatment, or where the child is incapable of consenting to treatment under the Health Care Consent Act, 1996, refuses or is unavailable or unable to consent to the treatment to remedy or alleviate the condition;

(k) the child's parent has died or is unavailable to exercise the rights of custody over the child and has not made adequate provision for the child's care and custody, or the child is in a residential placement and the parent refuses or is unable or unwilling to resume the child's care and custody;

(l) the child is younger than 12 and has killed or seriously injured another person or caused serious damage to another person's property, services or treatment are necessary to prevent a recurrence and the child's parent or the person having charge of the child does not provide services or treatment or access to services or treatment, or, where the child is incapable of consenting to treatment under the Health Care

Consent Act, 1996, refuses or is unavailable or unable to consent to treatment;

(m) the child is younger than 12 and has on more than one occasion injured another person or caused loss or damage to another person's property, with the encouragement of the person having charge of the child or because of that person's failure or inability to supervise the child adequately;

(n) the child's parent is unable to care for the child and the child is brought before the court with the parent's consent and, where the child is 12 or older, with the child's consent, for the matter to be dealt with under this Part; or

(o) the child is 16 or 17 and a prescribed circumstance or condition exists. 2017, c. 14, Sched. 1, s. 74 (2); 2020, c. 25, Sched. 1, s. 26 (1); 2021, c. 21, Sched. 3, s. 1 (2).

Best interests of child

74(3) Where a person is directed in this Part to make an order or determination in the best interests of a child, the person shall,

(a) consider the child's views and wishes, given due weight in accordance with the child's age and maturity, unless they cannot be ascertained;

(b) in the case of a First Nations, Inuk or Métis child, consider the importance, in recognition of the uniqueness of First Nations, Inuit and Métis cultures, heritages and traditions, of preserving the child's cultural identity and connection to community, in addition to the considerations under clauses (a) and (c); and

(c) consider any other circumstance of the case that the person considers relevant, including,

(i) the child's physical, mental and emotional needs, and the appropriate care or treatment to meet those needs,

(ii) the child's physical, mental and emotional level of development,

(iii) the child's race, ancestry, place of origin, colour, ethnic origin, citizenship, family diversity, disability, creed, sex, sexual orientation, gender identity and gender expression,

(iv) the child's cultural and linguistic heritage,

(v) the importance for the child's development of a positive relationship with a parent and a secure place as a member of a family,

(vi) the child's relationships and emotional ties to a parent, sibling, relative, other

member of the child’s extended family or member of the child’s community,

(vii) the importance of continuity in the child’s care and the possible effect on the child of disruption of that continuity,

(viii) the merits of a plan for the child’s care proposed by a society, including a proposal that the child be placed for adoption or adopted, compared with the merits of the child remaining with or returning to a parent,

(ix) the effects on the child of delay in the disposition of the case,

(x) the risk that the child may suffer harm through being removed from, kept away from, returned to or allowed to remain in the care of a parent, and

(xi) the degree of risk, if any, that justified the finding that the child is in need of protection. 2017, c. 14, Sched. 1, s. 74 (3)."

Appendix B: Ontario Child Welfare Eligibility Spectrum

The Ontario Eligibility Spectrum was first developed by Simcoe Children's Aid Society in the mid-1990's to assist in ensuring consistency of decision-making regarding referrals. At that time, each children's aid society (CAS) had their own list of 'reasons for service'. As a result, the likelihood of cases with the same issue being consistently screened in or out was very low, both across CASs and internally across teams and branches.

The original construction of the Spectrum incorporated some of Magura and Moses' (1986) Child Well-Being Scales categories and descriptors which have since been considerably modified. The Child and Family Services Act, The Revised Standards for the Investigation and Management of Child Abuse Cases (by the Children's Aid Societies) Under the Child and Family Services Act published by The Ministry of Community and Social Services in 2005, the OACAS Accreditation Standards, field practice wisdom and best practices research all informed the development of the Spectrum.

In 1995, a major revision of the Spectrum occurred and was assisted by the following Societies: Elgin, Haldimand-Norfolk, Muskoka, Peel, Perth, York and Sarnia. Other individuals and organizations also contributed to that refinement. In 1994, MCSS provided a grant to the OACAS to test the reliability and validity of the Eligibility Spectrum. The 1997 version of the Spectrum was developed based upon the results of that research and feedback received from extensive field use. The research was conducted by Professor Robert MacFadden and Deborah Goodman, then a doctoral candidate, at the Faculty of Social Work, University of Toronto, and leadership from the OACAS. A Research Advisory Committee consisting of representatives from Peel CAS, Toronto Catholic CAS, Leeds-Grenville Family and Children's Services and Essex Roman Catholic CAS assisted. Frontenac CAS, Toronto Catholic CAS, Huron CAS, Sudbury CAS, Metro Toronto CAS and Jewish Family and Child Service supplied data to the project. The result was the second major revision of the instrument. The Eligibility Spectrum was included in the Risk Assessment Model for Child Protection in Ontario, issued in October 1997. It has been in consistent use in all Children's Aid Societies in

Ontario since August 1998.

The 1995-2000 editions of the Spectrum were developed by Mary Ballantyne, Margaret Morrison, and Deborah Goodman, based upon the results of the research completed by the University of Toronto on the original instrument as well as the feedback from the many workers who used it. Minor revisions were made to the Eligibility Spectrum in 1999 in order to address issues identified by the field and to ensure consistency with amendments to the CFSA and with new Standards for Child Protection Cases. The Eligibility Spectrum (2006) reflected the new Transformation strategies (such as a broader range of permanency options like kinship care or custodial care and a new emphasis on partner violence affecting children) and the Ontario Differential Response Model for Child Protection Services (2005). The changes also made the eligibility tool consistent with both the Child and Family Services Act as amended by Bill 210 (November 30, 2006) and the Child Protection Standards in Ontario (February 2007). The most recent revisions to the Eligibility Spectrum were in 2021.

Appendix C: Ontario Child Protection Standards

Standard 1 directs the child protection worker to consider four key factors when determining the appropriate response to a referral. These factors are the vulnerability of the child, the identified protective factors for the child, their family and community, safety threats and risks, and patterns of previous child welfare involvement. The Standards (2016) reference that while this is not a causal finding, the Office of the Chief Coroner (2013), found that a "common risk factor in child death cases reviewed in 2012 were when families had three or more referrals to child welfare" (p. 29). The outcome of Standard 1 is a referral disposition, with three possibilities: a) Open for Child Protection or Other Child Welfare Services; B) Community Link; C) No Direct Contact/Information Only.

The child protection worker determines the appropriate type of investigation in Standard 2 (traditional or customized), with a family-based investigation requiring several steps involving: 1) face-to-face contact with the child alleged to be the victim, 2) interviews with other children in the home, 3) interviews of the child's non-abusing caregivers, 4) direct observation of the child's living situation, and 5) interviews with the alleged perpetrator of the maltreatment. Steps 6 to 11 may also be included, which involve direct observation of interactions, interviews with witnesses, completion of the eligibility spectrum to assist in determining risk, gathering of evidence from other professionals, and considering seeking warrants to access records. Where there is more than one CAS involved, the CASs jointly determine who will lead the investigation and this lead is responsible for completing the investigative steps outlined in Standard 2. Within the practice notes, workers are advised that in situations where domestic violence may be a concern, additional attention to safety planning with adult and child victims may be required. The practice notes state, "additional practice guidance on the issue may be found in training resources available through OACAS (see references section)".

Standard 3 directs that during the first face-to-face contact, the child protection worker is to, when conducting a family-based investigation, undertake a safety assessment in accordance with the safety assessment tool in the Ontario Child Protection Tools manual. If there are indications of injury or need for medical care, a

medical examination is to be arranged within 24 hours, and where there is no safety threat identified, the child protection worker is to review their assessment with the supervisor on the next working day. If the assessment identifies a safety threat, the child protection worker must develop a safety plan immediately, and the adequacy of this plan is to be assessed and approved by a supervisor prior to its implementation. The CAS developing a safety plan is directed to monitor this plan until the safety threat(s) have been eliminated, protective factors have been sufficiently enhanced or a longer-term service plan is required. Whenever there is a change in the of existing safety plans to mitigate risk and threats, a new safety plan must be conducted. Formal documentation of the safety assessment and plan must be completed within five days of the first face to face contact. Where more than one CAS is involved, the CASs jointly determine the lead agency responsible for completing the safety assessment and developing the safety plan. It should be noted that a safety plan is not intended to remedy or mitigate long-term risk of child maltreatment.

Standard 4 directs the child protection worker to conduct a risk assessment by using the risk assessment tools available in the Ontario Child Protection Tools Manual. These research-informed structured decision-making (SDM) tools are used to help the child protection worker consider the risk of future harm from maltreatment. Many factors should be critically analyzed by the child protection worker and they are encouraged to seek a variety of sources of information when undertaking a risk assessment. These tools are part of the Ontario Differential Response (DR) Model that permits the customization of the response, to meet the needs of the family. The risk assessment aids in identifying children and families at the greatest risk of future maltreatment where child protection services are needed to reduce risk, and those at a lower risk who may either be assisted with community services or, and those who are at a lower risk and whose cases can be closed following a protection investigation. During an investigation, only one risk assessment is required. The person completing the assessment is reminded that "[t]he risk assessment is meant to aid, not substitute for the exercise of clinical judgment as to risk of future harm to a child" (Ontario Child Protection Standards, p.57). In other words, the risk

assessment informs, but should not determine, the next steps in a particular situation and this notation in the standards reminds that clinical judgment must be applied to consider the entirety of the child's situation and the identifiable risks faced when determining the need for further services.

The results of the risk assessment are to be shared with the family identifying:

1. Children and families who are at the greatest risk of future maltreatment where child protection services are needed to reduce risk.

2. Children and families who are at lower risk of future maltreatment who may need to be assisted in accessing community services / resources to prevent child maltreatment or treat conditions that may raise the risk of maltreatment if left unattended.

3. Children and families who are at lower risk of future maltreatment and whose cases can be closed following a protection investigation.

Standard 5 outlines the process that should mark the conclusion of the child protection investigation. The child protection worker consults with their supervisor, having made a full case review and analysis of all relevant information. At this point, the child protection worker communicates key determinants to all relevant parties including:

1. Verification of the alleged or new child protection concerns.
2. A determination that a child is in need of protection.
3. A determination that a child and/or family requires ongoing child protection services and/or community services and resources.